DOCUMENT RESUME

ED 304 637 CG 021 511

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TITLE Age and Gender Differences in Community Recognition of Depression.
PUB DATE Nov 88
NOTE 24p.; Paper presented at the Annual Meeting of the Gerontological Society (41st, San Francisco, CA, November 18-22, 1988).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adults; *Age Differences; *Depression (Psychology); *Identification; *Knowledge Level; *Lay People; Sex Differences

ABSTRACT

Depression is a serious health problem and efforts are being made to educate laypeople in relevant ways about symptoms and the course of the disorder, availability of treatments, and related coping strategies. These programs have typically been initiated based more on assumptions regarding community knowledge of depression than on factual data. This study assessed knowledge of depression in a random sample of 527 community living adults between the ages of 18 and 93. Subjects were presented with vignettes which described a young or old protagonist with depressive symptoms. Respondents were asked to identify potential problems and possible solutions. A depression information measure followed. The results indicated that community residents were aware of many objective features of depression although they identified less information about treatment issues. Older respondents were the least informed of all subjects. Although there were no gender differences in objective knowledge among respondents, men were less likely to mention depression with regard to the vignettes. While many respondents appropriately acknowledged some of the characteristic symptoms, causes, and treatments for depression, a great deal of education still needs to occur. The findings from this study have implications for future work in the area of mental health and depression. (NB)

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ED304637

Age and Gender Differences in Community Recognition of Depression

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Running head: COMMUNITY RECOGNITION

Abstract

We assessed knowledge of depression in a random sample of 527 community living adults. Vignettes were presented which described a young or old protagonist with depressive symptoms. Respondents were asked to identify potential problems and possible solutions. A depresssion information measure followed. Results indicated that community residents are aware of many objective features of depression although they identified less information about treatment issues. Older respondents were least informed. Although there were no gender differences in objective knowledge, men were less likely to mention depression with regard to the vignettes. Suggestions for implementing more effective community interventions are discussed.

Objective and Subjective Assessment of Depressive Symptomatology

Depression is a serious health problem, recently targeted by national research initiatives. Depression may present in a number of ways with somewhat varied symptomatology. Symptoms are relatively interchangeable and depression is determined in part by constellations of factors. In addition, diagnostic considerations become even more problematic when dealing with more mature individuals in light of their changing social, psychological and biological interactions. This is further complicated by the observation that even professionals may identify and respond to symptoms of depression differently depending on the person's age (Perlick & Atkins, 1984). It is frequently, though erroneously, believed that depression is a normal response to aging, given the typical losses associated with later life in particular. Consequently many persons simply accept its occurrence as natural and normative.

While previous efforts at information dissemination have attempted to educate professionals about more subtle differentiations between depressive and other mental or physical disorders, federally-sponsored programs such as DART, Depression Awareness Recognition Treatment, have focused on improving community knowledge and interest in depression and related health issues. Efforts are also being made to educate laypeople in

relevant ways about symptoms and the course of the disorder, availability of treatments, and related coping strategies (Thompson, Gallagher, Nies & Epstein, 1983). However, these programs have been initiated based more on assumptions regarding community knowledge of depression rather than on factual data. Although there are numerous studies of incidence rates of depression in a variety of community samples (see Feinson, 1987), there has been relatively little attention focused on actual knowledge of depression by community dwellers. This may be due to both a lack of assessment devices developed for this purpose, a lack of acknowledgement that public knowledge is an important part of addressing this difficult and often elusive problem, as well as the lack of symptom specificity. On occasion, the obscure nature of depressive symptomatology eludes otherwise well-trained professional diagnosticians. Nevertheless, increased public awareness may improve access and utilization of available health care resources. Determining community level of knowledge is an important step that is generally overlooked. With increasing demands for accountability, and the need for greater responsiveness from social and educational systems, assessment does seem long overdue. Understanding what the community already knows and also what is not known improves the potential effectiveness of any educational endeavor.

In the present study, we were interested in determining adults' ability to identify depression. In order to understand the level of community knowledge, we measured objectively-based information about depression regarding symptoms, causes, coping strategies, and attitudes. We also assessed subjects' ability to identify depression and note effective coping strategies in more subjective descriptions of depression. Vignettes were constructed with a single protagonist exhibiting different symptom presentations of depression. As depression is a complex disorder with a variety of symptom patterns, we were also interested in whether or not recognition of depression was affected either by age or gender of the respondent as well as the age of the protagonist in the vignettes.

Method

Subjects

Our sample consisted of 527 adults, 18 to 93 years of age, from a midwestern, semi-rural community in Indiana. The mean age of the 306 females was 52.3 (19.5 s.d.) with an average of 12.5 (3.1 s.d.) years of education. The 221 men in this sample reported a mean age of 43.1 (17.1 s.d.) with 13.9 (2.9 s.d.) years of formal schooling. The majority of respondents were married (59%), and reported that their health was good or excellent (78%). The median income of sampled households was between $15,000 and

$20,000 yearly. Table 1 presents sample characteristics by age classifications and gender.

Insert Table 1 about here

Development and Description of Instruments

An initial pool of 130 items was developed to measure knowledge, causes, and information about the treatment of depression. The items were drawn from clinical measures of depression, DSM III-R (APA, 1987) descriptions of depression, and some stereotypic ideas regarding depression. In addition, as we were concerned that attitudes toward aging might affect assessment of depression, we included items assessing expectations regarding mental health and aging. Trained interviewers asked respondents to agree, disagree or indicate they did not know the correct response to each statement. On the attitude statements, participants were limited to either affirming or rejecting the statement. Considerable attention was paid to clarifying, shortening and refining items so they could be successfully relayed over the telephone. Statements were worded so that roughly half of the items required an affirmative response whereas the remaining half required a negative response to correctly acknowledge the statement. Three separate testings of the instrument using samples of 326, 184, and 225 college freshmen and

sophomores at a local university yielded the final 55-item measure which we called the Depression Information Measure (DIM). Item inclusion was determined by the point-biserial correlation of the item versus the composite score (than .35) and a satisfactory discrimination index (than .35) which compared high and low DIM scorers on individual items. The DIM included 20 items measuring knowledge of depressive symptoms, 16 items assessing causes of depression, 9 items tapping information about treatment issues and 10 attitudinal items related to mental health and aging (see Appendix A). Response tallies resulted in four separate subscales in addition to a combined score from the first three subtests indicating knowledge of depression. Higher scores indicated more accurate information about depression.

In addition, a series of five vignettes were pretested with samples of 25 and 31 college undergraduates at the same university in order to clarify and simplify wording of the vignette and to modify follow-up questions. The standardized follow-up questioning required the interviewee to answer whether the protagonist had a problem and to try to specify the nature of the difficulty. After hypothesizing about what might be wrong with the protagonist in the vignette, the respondent was asked to identify appropriate actions to ameliorate the difficulty. Individuals who did not feel the protagonist had a problem were read the next vignette without any further questioning. After

hearing the vignettes and responding to the follow-up questions, subjects were asked to briefly recall salient parts of the vignettes. None of the subjects had any difficulty recalling the gist of the vignettes, suggesting that information could be verbally presented and then retained for at least a brief time period.

Our series of vignettes included a succinct description of a protagonist exhibiting symptoms typical of a major depressive disorder. Since we were also interested in whether more somaticized depression would be recognized in a community sample, given its greater ambiguity for professionals, this type of vignette was also developed. Due to time considerations imposed by the length of the phone interviews, we ultimately selected these vignettes for final use in the telephone interview (see Appendix B).

Procedure

Participants were selected through a random digit dialing technique and agreed to participate in a 15 minute telephone interview which assessed knowledge of mental health-related issues presented through both vignettes and likert-type statements about depression. After agreeing to participate, subjects were read one of the preselected vignettes describing either a young (29) or older (69) adult with a classic depression, including symptoms such as sad affect and withdrawal. Subjects were then asked to

identify potential problems; related questions addressed potential solutions and respondents' assumptions regarding health care.

Upon completing the questions for the vignette, subjects were read a second story describing masked depression, exemplified by somatic complaints and irritability. The story protagonist in this second vignette was either 26 or 66, depending on the protagonist's age in the first vignette. Order of protagonist age was counterbalanced, with each subject responding to one young and one old protagonist. The stories were presented in the same sequence for all subjects, and the gender of the protagonist was left ambiguous by using gender neutral names.

After completing the vignettes, subjects were asked to respond to the DIM, which consisted of objective items measuring knowledge of the symptoms, causes, and treatments for depression as well as attitudes regarding depression and aging. Demographic information was collected at the end of the interview. The interviewer then briefly explained the general purpose of the study and thanked each respondent for their participation.

Results

Objective Recognition of Depression

Our findings indicate that community dwellers are generally aware of many objective features of depression as measured by the DIM. Both men and women correctly identified 60% of the statements although they performed more poorly on statements

regarding appropriate treatments for depression. Correlational analyses are presented in Table ?. Although correlations were

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Insert Table ? about here

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relatively small, aging was inversely related to knowledge of symptoms and causes of depression. In addition, general education was related to aging and also to overall DIM information. The various subscales were significantly related to each other. Interestingly, older subjects had the most negative attitudes about depression and aging.

Using the percentage of correct responses of each DIM subscale in a 2 (Gender) X 3 (Age) MANOVA, we found age effects with the middle-aged and young adults performing better than the older adults, $F(1,1026) = 7.35$, p .0001 using Wilks' criterion. Interestingly, although there were gender differences in educational background, $t\ (221,304) = 5.31$, $p = .0001$, there were no significant gender differences on overall DIM performance or for any of its subscales.

Subjective Recognition of Depression

Analysis of recognition responses to the major unipolar depression described in the first vignette by gender yielded a $x^2\ (523) = 8.01$, $p = .005$, with a higher proportion of women recognizing this as the potential problem. Approximately 29% of

the men and 41% of the women specifically stated depression was a probable factor in this vignette. Nevertheless, ability to recognize depressive symptoms, causes, treatments and attitudes on the DIM accounted for only 3% of the variability ($r = .17$) in determining which individuals could generate depression as a potential problem in the vignettes. Relatively few respondents (6.7% of males and 11.9% of females) correctly suggested depression as a probable difficulty in the second vignette which described somatic difficulties.

Identification of Coping Strategies

Using a summation of appropriate coping strategies as the dependent variable, a 2 (gender) X 3 (age) X 2 (young or old protagonist) X 2 (high or low DIM score) ANOVA yielded main effects for gender, $F(1,494) = 24.2$, $p = .0001$, with women mentioning more coping strategies, and for age, $F(2,494) = 3.76$, $p = .024$ with Duncan's multiple range test indicating that older adults mentioned fewer coping strategies than the young and middle aged adults. There were also main effects for protagonist age, $F(1,494) = 8.28$, $p = .004$, with the older protagonist eliciting more coping suggestions, and for knowledge of depression, $F(1,494) = 41.76$, $p = .001$, with higher DIM scores associated with more self-generated coping strategies. In addition, there was a 2 way interaction between gender and age, $F(2,494) = 5.75$, $p = .003$ indicating that middle-aged men were more effective at

generating coping strategies than younger and older men. For females, the youngest group generated the most coping strategies, followed by the middle-aged women and finally the older women. However, women in each age group suggested more coping strategies than any of the three male groups. There was also a gender by knowledge interaction, $F(1,494) = 7.6$, $p = .006$, which suggested that knowledgeable women were most likely to suggest additional ways of coping.

A 4 factor ANOVA with the second vignette yielded fairly similar effects. Females generated more coping strategies, $F(1,494) = 9.43$, $p = .002$, as did younger and middle-aged adults as compared to older adults, $F(2,494) = 5.09$, $p = .006$. In addition, more coping strategies were suggested when individuals responded to older protagonists as contrasted with younger protagonists, $F(1,494) = 10.97$, $p = .001$, and by individuals with higher as opposed to lower DIM scores, $F(1,511) = 11.7$, $p = .0007$. There was also an interaction between gender and age, $F(2,494) = 4.59$, $p = .01$, indicating that middle-aged respondents of both genders might be most likely to suggest interventions. As expected, this more ambiguous vignette, generated more discussion of possible coping techniques.

Discussion

Although many adults living in the community appropriately acknowledge some of the characteristic symptoms, causes, and

treatments for depression, a great deal of education still needs to occur. Notwithstanding obvious limitations in the depth of our depression information gathering, this study does randomly sample a typical nonurban midwestern community. There was considerable variability in objective knowledge of depresssion; however, despite educational differences, there were no gender differences on objective information. When we used the more ambiguous vignettes we found that women were better at recognizing and identifying a typical major depression as well as identifying potential coping strategies. Although women had no more knowledge about depression than the more formally educated men, they were better able to label depression in more subjective circumstances, probably due to gender socialization differences.

Individuals were also better at identifying coping strategies when the vignette protagonist was displayed as older, which may suggest more willingness to intervene with depression in older adults. It may also suggest that depression is viewed as requiring more active interventions with the elderly, given the traditional societal view of increasing passivity in the aged. Perhaps, because of accumulating stresses and losses in late life, depression seems more expected and predictable, and consequently more difficult to counteract. However, whether the protagonist was young or old did not differentially affect recognition of depression. Not surprisingly, individuals with more knowledge

about depression were more likely to generalize this information to the vignette protagonists. Given the weak nature of the relationship between objective knowledge and subjective recognition of depression, it is important that mental health professionals and educators be as explicit as possible, offering a variety of concrete and specific everyday examples of how our general knowledge of this disorder can be used to better understand and aid others. However, it is important to be aware that many of our subjects did not mention depression or any other emotional or psychological indicants as potential factors in the vignettes.

Although these findings suggest that certain knowledge domains and certain types of respondents may have a limited understanding of depression, different types of communities are likely to evidence considerable variability in their knowledge of depression. Therefore, assessing community knowledge is a useful first step in any educational endeavor. We also found that it proved to be an excellent way to encourage community interest in depression while providing information that allowed us to more effectively target out educational efforts. Although different areas of inquiry might be included as needed, we can recommend the DIM and vignettes as appropriate information-gathering methods that elicit interest and curiosity in the community while ascertaining their knowledge base.

We believe that our findings have implications for future work in the area of mental health and depression. Although it is certainly important to increase accessibility to mental health resources, it is also necessary to further educate adults about depression. Older adults could particularly benefit from this information given their poorer understanding of depression and more negative attitudes. Educational programs could highlight the nature and causes of depression while underscoring that treatments are available and effective. At least some of this programming should be specifically targeted toward older adult males, given their poorer recognition of problems and greater risk for suicide (Stoudemire & Blazer, 1985). Dissemination of information should particularly strive to promote generalization to real-life circumstances. Since men are less likely to apply information, appropriate male role models could present information which may enhance identification and generalization.

It is important to convey that depression is a disorder that may seriously impair individuals of either gender, physically as well as psychologically. Failure to recognize the symptoms and to obtain appropriate treatment can be fatal, whereas interventions are often extremely effective and relatively noninvasive. Teaching people about depression and the importance of mental health will result in improved quality of life for all.

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Table 1

Sample Demographics

	FEMALES			MALES		
	YOUNG (18-35) n=89	MIDDLE (36-60) n=85	OLDER (61-93) n=133	YOUNG (18-35) n=94	MIDDLE (36-60) n=78	OLDER (61-87) n=50
Age	$\bar{X}$ = 27.2 (4.64)	$\bar{X}$ = 48.0 (8.08)	$\bar{X}$ = 71.07 (6.68)	$\bar{X}$ = 27.4 (4.97)	$\bar{X}$ = 45.5 (7.22)	$\bar{X}$ = 68.4 (6.76)
Education	$\bar{X}$ = 13.8 (2.72)	$\bar{X}$ = 12.8 (2.89)	$\bar{X}$ = 11.5 (3.07)	$\bar{X}$ = 13.8 (2.44)	$\bar{X}$ = 14.9 (3.42)	$\bar{X}$ = 12.7 (2.75)
Race						
Caucasian/Hispanic	91%	94%	95%	87%	91%	98%
Black	1%	6%	4%	4%	5%	2%
Asian	5%	0%	0%	7%	1%	0%
Native American	0%	0%	1%	1%	1%	0%
Refused	3%	0%	1%	1%	2%	0%
Marital Status						
Married	49%	70%	45%	54%	74%	82%
Divorced/Separated	17%	16%	6%	9%	14%	6%
Widowed	0%	10%	45%	0%	1%	10%
Never married	34%	4%	4%	37%	10%	2%
Job Status						
Working Full Time	48%	41%	5%	69%	86%	28%
Working Part Time	18%	19%	8%	10%	0%	9%
Student	34%	39%	0%	21%	13%	0%
Retired	0%	0%	87%	0%	0%	64%
Income						
$4999 or less	8%	5%	7%	8%	0%	2%
$5000 to 9999	5%	8%	24%	7%	4%	16%
$10,000 to 14,999	14%	8%	29%	10%	8%	14%
$15,000 to 19,999	22%	12%	11%	13%	5%	8%
$20,000 to 24,999	8%	6%	8%	14%	8%	10%
$25,000 to 34,999	13%	18%	5%	18%	18%	20%
$35,000 to 49,999	18%	15%	2%	22%	32%	6%
$50,000 or more	6%	17%	0%	2%	23%	8%
Refused or don't know	6%	12%	14%	7%	3%	16%
Perception of Health						
Excellent	39%	39%	22%	46%	42%	30%
Good	47%	33%	44%	47%	39%	40%
Fair	14%	24%	23%	6%	13%	22%
Poor	0%	4%	11%	1%	6%	8%

Table 2 (N=527)

ZERO ORDER CORRELATIONS

	Age	G	E	I	DIM	S	C	T	A	PR1	DR1	PR2	DR2
Age (A)	1.00												
Gender (G)	.24***	1.00											
Education (E)	-.29***	-.23***	1.00										
Income (I)	.13**	.04	-.03	1.00									
DIM	-.17***	-.04	.33***	-.07	1.00								
Symptom (S)	-.21***	-.07	.31***	-.08	.39***	1.00							
Causes (C)	-.10*	.03	.31***	-.03	.78***	.49***	1.00						
Treatments (T)	-.01	-.03	.14**	-.05	.69***	.43***	.46***	1.00					
Attitudes (A)	-.22***	.00	.31***	.00	.32***	.30***	.26***	.19***	1.00				
Problem Recognition Vignette 1 (PR1)	.07	.06	.07	-.03	.21***	.20***	.14***	.16***	.12**	1.00			
Depression Recognition Vignette 1 (DR1)	-.06	.12**	.05	-.02	.17***	.17***	.11**	.08	.11**	.25***	1.00		
Problem Recognition Vignette 2 (PR2)	-.04	.07	.01	-.05	.23***	.21***	.15***	.21***	.07	.21***	.03	1.00	
Depression Recognition Vignette 2 (DR2)	-.13**	.06	.13**	-.08	.18***	.16***	.15***	.10*	.18***	.05	.16***	.14***	1.00

Appendix A

Depression Information Measure

This next section is a little different. I'll read some statements. Tell me if you agree, disagree, or don't know whether these statements describe someone who is depressed.

A D DK 1. Depressed people rarely feel nervous.

A D DK 2. They don't feel particularly guilty.

A D DK 3. They seldom cry.

A D DK 4. Depressed people feel that they may be punished.

A D DK 5. They have more digestive problems than usual.

A D DK 6. They get annoyed or irritated more easily than they used to.

A D DK 7. They don't sleep as well as they used to.

A D DK 8. Depressed people feel like hurting themselves.

A D DK 9. They have more headaches than usual.

A D DK 10. They seem to have difficulty remembering things.

A D DK 11. They like being around other people.

A D DK 12. They have much less interest in sex than they used to.

A D DK 13. Their appetite is the same as it used to be.

A D DK 14. They are easily cheered up by their family or friends.

A D DK 15. They believe that people like them.

A D DK 16. Depressed people prefer to avoid their usual activities.

A D DK 17. They may be preoccupied with illness.

A D DK 18. It is easy for them to make decisions.

A D DK 19. They worry about physical problems such as aches or pains or upset stomach or constipation.

A D DK 20. They become absorbed in their work.

I'm going to read you possible reasons why people become depressed. Tell me if you agree, disagree, or don't know.

A D DK 21. It is one's own fault if you become depressed.

A D DK 22. Depression can result if you are not doing enough enjoyable activities.

A D DK 23. Sometimes people become depressed for no reason at all.

A D DK 24. Depression occurs when people weren't properly cared for as children.

A D DK 25. Society's values make people become depressed.

A D DK 26. When people become depressed, it is because their families don't care enough.

A D DK 27. When someone close to you dies, depression will always result.

A D DK 28. People can become depressed when they cannot control what happens to them.

A D DK 29. People become depressed when they have physical problems.

A D DK 30. The way you think about things can make you depressed.

A D DK 31. Depression can result from hormone imbalance.

A D DK 32. Depression is God's way of punishing people.

A D DK 33. Depression can be inherited.

A D DK 34. If someone becomes depressed, it is because they are a negative person.

A D DK 35. Feeling guilty makes some people depressed.

A D DK 36. Other people can make you depressed.

I am going to read some ways one might deal with depression. Please answer agree, disagree, or don't know.

A D DK 37. Depression can always be treated.

A D DK 38. People can get over their depression naturally without any special treatment.

A D DK 39. Talking with friends is all it takes to get over depression.

A D DK 40. Anti-depressant drugs are effective.

A D DK 41. Learning new ways to think about problems can help depression go away.

A D DK 42. Depression is preventable.

A D DK 43. Religious counseling is an effective treatment.

A D DK 44. People who are depressed should not use alcohol to deal with depression.

A D DK 45. Psychological counseling is an effective treatment.

A D DK 46. If someone is feeling depressed, getting out and exercising can make then feel better.

A D DK 47. Prayer is an effective way to treat depression.

A D DK 48. Electric shock may be an effective treatment.

Now I'm going to read some short statements that ask for an opinion. Please respond agree or disagree.

A D 49. Becoming old is a time to look forward to.

A D 50. Older women and men are attractive because they have character.

A D 51. It is hard to enjoy life when you're old.

A D 52. Retirement at age 65 is a good idea because it makes a job available for a young person.

A D 53. Younger people have all the advantages in our society.

A D 54. Memory problems are a natural result of getting old.

A D 55. People naturally get depressed as they get older.

A D 56. Mental health resources should be used to help depressed older people.

A D 57. It is more important to help younger people who are depressed because they have their whole lives ahead of them.

A D 58. Depression can be treated whether you are young or old.

Appendix B -- Vignettes

To begin with I'm going to read you a short story and then I'll ask you a few questions about it.

Jean, age 29/69, used to be very active in church but isn't now. For the past several months, Jean stays home most of the time and shows very little interest in family activities. Jean doesn't even care about seeing friends anymore.

1. If Jean were someone close to you, would you think something was wrong or not? WRONG NOT WRONG -- (reasons?)
   Go to the next story by saying "Let me read you another story."
2. What (would you think was wrong)?
3. Should Jean ignore these feelings? YES NO
   Skip to 7 Ask 4
4. Should Jean wait and see if these feelings change? YES -- NO
   Ask # 5
5. Should Jean take care of it strictly on his/her own, without any outside help? YES -- NO
   6. What should Jean do?
7. Can you think of anything else Jean could do:
8. Does this situation seem very serious to you? YES -- NO
   (Why do you say that?

Go to the next story by saying: "Let me read you a second story."

Pat, age 66/26, quit working recently. Pat used to be pleasant, but is now irritable and hard to live with. Even little things make Pat angry. Pat complains alot about backaches and headaches and seems to sleep alot, and always looks at the negative side of everything.

1. If Pat were someone close to you, would you think something was wrong or not? WRONG NOT WRONG -- (reasons?)
   Go to the next story by saying "Let me read you another story."
2. What (would you think was wrong)?
3. Should Pat ignore these feelings? YES NO
   Skip to 7 Ask 4
4. Should Pat wait and see if these feelings change? YES -- NO
   Ask # 5
5. Should Pat take care of it strictly on his/her own, without any outside help? YES -- NO
   6. What should Pat do?
7. Can you think of anything else Pat could do?
8. Does this situation seem very serious to you? YES -- NO
   (Why do you say that?)